STATE OF NEW JERSEY

STATE EMPLOYEE GROUP DENTAL PROGRAM

THE DENTAL EXPENSE PLAN AND THE DENTAL PLAN ORGANIZATIONS

FOR STATE EMPLOYEES

Department of the Treasury
Division of Pensions and Benefits

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The benefits and provisions of the State Employee Group Dental Program are subject to changes by the legislature, courts, and other officials. While this booklet outlines the benefits of the Program, it is not a final statement.

As an employee of the State of New Jersey, you are entitled to enroll in either the Dental Expense Plan offered by Aetna, or one of the many Dental Plan Organizations participating in the State Employee Group Dental Program. You may also choose not to enroll in any dental plan at all.

The group dental program is open to state employees who are eligible to participate in the State Health Benefits Program.

SECTION ONE

GENERAL INFORMATION

INTRODUCTION

Eligibility for coverage in the State Group Dental Program is determined by the State Health Benefits Program (SHBP). The State Health Benefits Commission is the executive organization responsible for overseeing the SHBP. The State Health Benefits Commission includes the State Treasurer as the Chairperson, the Commissioner of the Department of Banking and Insurance and the Commissioner of the Department of Personnel or their designated representatives. The Director of the Division of Pensions and Benefits is the Secretary to the State Health Benefits Commission. The Division of Pensions and Benefits, specifically the Health Benefits Bureau and the Bureau of Policy and Planning, are responsible for the daily administrative activities of the SHBP.

State law and the New Jersey Administrative Code govern the SHBP. Although every effort has been made to ensure the accuracy of this publication, if there are discrepancies between the information presented here and the law, or regulations, the latter will govern.

This booklet describes the dental benefit plans that are available to eligible full-time employees of the State, State universities and colleges, and certain independent State agencies under the State Group Dental Program. Before making any enrollment decision, you should carefully review the standards of eligibility and the conditions, limitations, and exclusions of the coverage under each plan. The complete terms of the State Group Dental Program are described in the Dental Expense Plan contract with amendments and the Dental Provider Organization contracts.

If, after reading this booklet, you have any questions, comments, or suggestions regarding this material please write to the Division of Pensions and Benefits, PO Box 295, Trenton, NJ 08625-0295, e-mail us at *pensions_nj@tre.state.nj.us* or call us at (609) 292-7524.

DENTAL PLANS

The dental program provides a choice between two different types of plans:

- The **Dental Expense Plan** is a traditional indemnity plan that allows you to obtain services from any dentist. After you satisfy the $50 annual deductible (the deductible applies to non-preventive services only), you are reimbursed a percentage of the reasonable and customary charges for the services that are covered under the plan. This plan is administered under a contract between the State Health Benefits Commission (SHBC) and Aetna Life Insurance Company (Aetna).
- The **Dental Plan Organizations** are individual prepaid plans offering services through a network of dental providers. You may enroll in one of several Dental Plan Organizations (DPOs). To obtain services, you must use a dentist who is a member of the DPO you selected. The cost for most services are prepaid, but certain services require an additional copayment. You will not be covered for services if you go to a dental provider who is not a member of your DPO, unless referred by a DPO dentist.

Levels of Coverage

There are four levels of coverage:

- **Single**: covers the employee only
- **Member and spouse**: covers the employee and his/her spouse

- **Parent and child**: covers the employee and all enrolled eligible children
- **Family**: covers employee, spouse, and all enrolled eligible children

Dental Plan Premiums

The cost for participation in either plan is shared by the State and participants. Premium payments are made through payroll deductions. For a current list of rates and payroll deduction schedules, please see your benefits administrator. Employee premiums can be paid on a pre-tax basis through participation in the Premium Option Plan (POP) of the State's IRC Section 125 Program, Tax$ave. Participation in POP is automatic unless you specifically decline enrollment. See Appendix C on page 34 for more information on Tax$ave.

ELIGIBILITY AND ENROLLMENT

Enrollment in a dental plan is optional. If you do not enroll when first eligible, you will have the option to enroll each year during the annual SHBP Open Enrollment Period.

In deciding whether to enroll and which plan to choose, you should consider the differences in out-of-pocket costs, the covered services between the Dental Expense Plan and a DPO, and the degree of flexibility that you may want in selecting a dentist. You should also recognize that you must remain in any plan you select for at least 12 months.

Eligibility

To be eligible for State Group Dental Program coverage, you must be a full-time employee, or be an appointed or an elected officer, of the State of New Jersey. Generally, you are considered to be a full-time employee if you are employed for at least 35 hours per week on a 10- or 12-month basis and have completed the required waiting period.

In the description of enrollment procedures, this booklet makes reference to **biweekly** employees and **monthly** employees.

- Biweekly employees are paid through the State's Centralized Payroll Unit with benefits provided on a biweekly pay period basis.
- Monthly employees are employees of State universities and colleges, independent State agencies, and State legislators and aides. Their benefits are provided on a calendar-month basis.

Eligible Dependents

If you enroll, you may also enroll the following dependents:

- Your spouse.
- Your unmarried children (including step-children, legally adopted children, foster children, and legal wards) under the age of 23 who are substantially dependent upon you for support and maintenance and who:
  - live with you in a normal parent-child relationship; or
  - reside at school but who have a permanent domicile with you and whom you support; or
  - do not live with you, but whom you are legally required to support. Proof of the legal requirement of support is necessary.

Ineligible dependents are as follows:

- A child over age 23 at the time of enrollment.
- A child's eligibility ends on December 31 of the year in which the child reaches age 23.
- Your child no longer resides with you in a parent/child relationship.
- You are divorced and the child does not live with you and you are not legally required to support your child.
- If a child marries before reaching age 23, eligibility ends on the date of the marriage.
- A child is not eligible if on active duty in the armed forces of any country.
- Neither you, your spouse, nor your children are eligible if you or your spouse are eligible for dental coverage through active service in the armed forces of any country.
- Your spouse or a child is not eligible if your spouse or child is already covered in the State Group Dental Program as an employee or a dependent of another employee.
- If you and your spouse are both covered as employees, a child can only be listed as a dependent on one coverage.
- Upon divorce, your ex-spouse is not eligible.

Enrollment

A new employee must submit a completed *State Group Dental Program Application* to your Human Resources Representative within 60 days of employment. If you do not enroll within 60 days of employment, you must wait to enroll during the Annual Open Enrollment Period. See "When Coverage Begins" on page 6 for effective dates of coverage.

If you do not enroll because of other coverage and you lose that coverage, you can be enrolled providing you submit a completed application to your Human Resources Representative within 60 days of the event. Coverage will be effective the first day of the payroll period in which the event occurs if you are a biweekly employee. For all other employees, the coverage will be effective on the date of the event.

Enrolling Dependents

You may enroll your eligible dependents when you enroll, or during any SHBP Open Enrollment Period. See "When Coverage Begins" on page 6 for effective dates of coverage.

If you have a new dependent, you may enroll the dependent effective the date you acquired the dependent provided you submit a completed application within 60 days of the dependents's eligibility. If you do not enroll the new dependent within 60 days, you must wait until the annual Open Enrollment Period.

If you do not enroll an eligible dependent because of other coverage and that coverage is lost, you can enroll that dependent providing you submit a completed application within 60 days of the event. Coverage for that dependent will be effective the first day of the payroll period in which the event occurs if you are a biweekly employee. For all other employees, the coverage will be effective on the date of the event.

Dual Dental Program Enrollment is Prohibited

Two employees who are married to each other and who are **both** SHBP members are prohibited from duplicate coverage in State Group Dental Program plans. You and your spouse may belong to a State Group Dental Program plan as an employee or as a dependent but not as both.

For example, if two employees are married to each other, each may elect to enroll for single coverage only under any of the State Group Dental Program plans, or one employee may enroll the other dependent if the other person waives their dental plan coverage.

Furthermore, two employees married to each other cannot each enroll the same children as dependents under the State Group Dental Program plans.

When Coverage Begins

Upon enrollment, coverage for you and your enrolled eligible dependents will begin as follows:

- If you enroll at the time you begin employment, your coverage begins approximately two months after the start of your employment. If you are paid through the State's Centralized Payroll Unit, your coverage begins on the first day of your fifth payroll period. If you are ***not*** paid through the State's Centralized Payroll Unit, your coverage begins on the 61st day of employment. (Note: See orthodontic exception below.) Coverage for enrolled eligible dependents is effective the same date as your coverage.
- If you enroll during the Open Enrollment Period, your coverage begins on the established Open Enrollment Period effective date.
- If you enroll under the provisions described above because of loss of other coverage, your State Group Dental Program coverage begins on the first day of the payroll period in which the event occurs if you are a biweekly employee, provided an application was submitted within 60 days of the loss of coverage. For all other employees, coverage will begin the date of the event. You will be responsible for paying the appropriate premiums.
- If you enroll under the Dental Expense Plan (Indemnity Plan), your coverage for any eligible **orthodontic** expense becomes effective only after you have been employed full-time for 10 months. If you elect a Dental Plan Organization (DPO), your coverage for eligible **orthodontic** expense becomes effective when your dental coverage begins.

When Dependent Coverage Begins

- If you enroll a dependent when you enroll as a new employee, the dependent's coverage begins when your coverage begins.
- If you add a new dependent and submit a completed application within the 60-day period before or after a qualifying event (birth, marriage, adoption, loss of coverage due to a dependent's change of employment, etc.), the dependent's coverage begins on the first day of the payroll period in which the event occurs if you are a biweekly employee. For all other employees, the coverage will be effective on the date of the event.
- For those dependents not added when eligible but whom you wish to add during the annual Open Enrollment Period, the dependent's coverage begins on the effective date established for the Open Enrollment Period.

Change of Coverage

Your coverage may be changed or canceled under the following circumstances:

- You may change from one plan to another only during the annual Open Enrollment Period.
- You must also remain in a plan for 12 months before you can transfer to another plan during the next annual Open Enrollment Period.
- You may cancel your coverage at any time after 12 months of participation.
- You may cancel coverage for a dependent at any time after the dependent's 12 months of participation.
- If you enroll in a Dental Plan Organization (DPO), you may change your DPO only during the annual Open Enrollment Period, or when your DPO cannot provide you a dental provider within 30 miles of your home.

When Coverage Ends

Dental Expense Plan and DPO coverage ends:

- If you are no longer eligible due to a change in your employee eligibility status; or
- you fail to make the required payments for your enrollment; or
- you voluntarily terminate coverage after 12 months of participation.

When Dependent Coverage Ends

Dental expense plan and DPO coverage for your dependents ends:

- When a dependent is no longer eligible; or
- when your coverage ends; or
- you voluntarily terminate the dependent's coverage after 12 months of participation.

EXTENSION OF COVERAGE PROVISIONS

If Eligibility Ends While Undergoing Treatment

***Dental Expense Plan only**:*

If coverage for you or a dependent is terminated, the coverage will be extended to cover the following procedures for 30 days following the end of the coverage:

- An appliance or modification of an appliance for which the impression was taken while the person was covered.
- A crown or restoration for which a tooth was prepared while the person was covered.
- Root canal therapy for which the pulp chamber was opened while the person was covered.

Dental Provider Organizations only:

If coverage for you or a dependent is terminated and the DPO continues to participate in the SHBP, the coverage will be extended to cover the following procedures to the comple-

tion of the procedure:

- An appliance or modification of an appliance for which the impression was taken while the person was covered.
- A crown or restoration for which a tooth was prepared while the person was covered.
- Root canal therapy for which the pulp chamber was opened while the person was covered.

If DPO Terminates Participation in the SHBP

If your DPO leaves the State Group Dental Program you will be given the opportunity to join another State Group Dental Program plan. For services that have already begun prior to plan termination including a full course of orthodontic treatment, coverage for those services for you and your dependents will be extended at no additional cost to you except for the remaining portion of the copayment that has not yet been paid.

For Children Over the Age of 23

A child over the age of 23 who is incapable of self-support due to mental illness, mental retardation, or physical disability, may be continued for coverage provided the child had been enrolled prior to reaching age 23 and the disability occurred before age 23. You must prove the child is incapable of self-support and the continuation of coverage must be approved by the State Health Benefits Program (SHBP). To request continued coverage, call or write the Division of Pensions and Benefits, Health Benefits Bureau, for a *Continuance for Dependent With Disabilities* form. The form and proof of the child's condition must be given to the Division no later than 31 days after the date coverage would normally end. Since coverage for children ends on December 31 of the year they turn 23, you have until January 31 to file the *Continuance for Dependent With Disabilities* form. Coverage may continue only while (1) you are still covered through the SHBP, (2) the child is disabled, and (3) the child is unmarried. The Division will contact you periodically to verify that the covered child remains eligible for continued coverage.

Leave Of Absence

If you are on an authorized leave **with** pay, your coverage is automatically continued.

If you are on an authorized leave **without** pay, you may continue your coverage for up to six biweekly pay periods or three months. You must pay the entire cost (employee and employer contributions) in advance except in the case of Workers' Compensation, Family Leave, and Furlough. In these cases, you pay only the cost of the employee contribution. (See chart on page 9.)

EXTENSION PROVISIONS FOR DENTAL BENEFITS

Status	Maximum Duration	Cost to Employee
Unpaid Leave of Absence for Illness and Personal Reasons (other than for family leave)	Six pay periods or three months	Full premium for level of coverage (employer and employee share)
Workers' Compensation (off payroll)	Duration of Workers' Compensation period	Employee share only
Family Leave (with or without pay)	Six pay periods or three months	Employee share only
Furlough	Duration of furlough	Employee share only
Extended Furlough	Duration of extended furlough	Full premium for level of coverage (employer and employee share)

COBRA COVERAGE

Continuing Coverage When it Would Normally End

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) is a federally regulated law that gives employees and their eligible dependents the opportunity to remain in their employer's group coverage when they would otherwise lose coverage because of certain qualifying events. COBRA coverage is available for limited time periods, and the member must pay the full cost of the coverage plus an administrative fee. The member/dependent can increase his or her level of coverage, i.e., add dependents or elect coverage (s)he did not have as a member/dependent.

Leave taken under the federal and/or State Family Leave Act is no longer subtracted from your COBRA eligibility period.

COBRA enrollees have the same rights to coverage at Open Enrollment as are available to active employees. This means that you or a dependent who elected to enroll under COBRA are able to enroll, if eligible, in any SHBP medical, dental, or prescription drug coverage during the SHBP Open Enrollment Period regardless of whether you elected to enroll for the coverage when you went into COBRA. This affords a COBRA enrollee the same opportunity to enroll for benefits during the SHBP Open Enrollment Period as an active employee. However, any time of non-participation in the benefit is counted toward your maximum COBRA coverage period. If the State Health Benefits Commission makes changes to the health insurance package available to active employees and retirees, those changes apply equally to COBRA participants.

COBRA Events

Continuation of group coverage under COBRA is available if you or any of your covered dependents would otherwise lose coverage as a result of any of the following events:

- Termination of employment (except for gross misconduct).

- Death of the member.
- Reduction in work hours.
- Leave of absence.
- Divorce or legal separation.
- Loss of a dependent child's eligibility through independence (moving out of household), the attainment of age 23, or marriage.

The occurrence of the COBRA event must be the reason for the loss of coverage for you or your dependent to be able to take advantage of the provisions of the law. If there is no coverage in effect at the time of the event, there can be no continuation of coverage under COBRA.

Cost of Coverage

If you choose to purchase COBRA benefits, you pay 100 percent of the cost of the coverage plus a 2 percent charge for administrative costs.

Duration of Coverage

COBRA coverage may be purchased for up to 18 months if you or your dependents become eligible because of termination of employment, a reduction in hours, or a leave of absence.

Coverage may be extended up to 11 additional months, for a total of 29 months, if you have a Social Security Administration approved disability (under Title II or XVI of the Social Security Act) for a condition that existed when you enrolled in COBRA or began within the first 60 days of COBRA coverage. Coverage will cease either at the end of your COBRA eligibility or when you obtain Medicare coverage, whichever comes first.

COBRA coverage may be purchased by a dependent for up to 36 months if (s)he becomes eligible because of your death or divorce, or (s)he becomes ineligible for continued group coverage because of marriage, attaining age 23, or moving out of the household, or because you elected Medicare as your primary coverage.

If a second qualifying event occurs during the 18-month period following the date of any employee's termination or reduction in hours, the beneficiary of that second qualifying event will be entitled to a total of 36 months of continued coverage. The period will be measured from the date of the loss of coverage caused by the first qualifying event.

Employer Responsibilities Under COBRA

The COBRA law requires employers to:

- notify you and your dependents of the COBRA provisions when you and your dependents are first enrolled;
- notify you, your spouse, and your children of the right to purchase continued coverage when they become aware of a COBRA event that causes a loss of coverage;
- send the COBRA Notification Letter and a COBRA Application within 14 calendar days of receiving notice that a qualifying event has occurred; and
- maintain records documenting their compliance with the COBRA law.

Employee Responsibilities Under COBRA

The law requires that you and your dependents:

- notify your employer that a divorce, legal separation, or death has occurred or that

your child has married, moved out of your household, or reached age 23 – notification must be given within 60 days of the date the event occurred;

- file a COBRA application within 60 days of the loss of coverage or the date of the COBRA Notice provided by your employer, whichever is later;
- pay the required monthly premiums when billed in a timely manner and retroactive to the COBRA effective date.

Termination of COBRA Coverage

Your COBRA coverage through the SHBP will end when any of the following situations occur:

- your eligibility period expires;
- you fail to pay your premiums in a timely manner;
- after the COBRA event, you become covered under another group insurance program (unless a pre-existing clause applies);
- you voluntarily cancel your coverage.

APPEAL PROCEDURES

You or your authorized representative may appeal and request that your dental plan reconsider any claim or any portion(s) of a claim for which you believe benefits have been erroneously denied based on the plan's limitations and/or exclusions. This appeal may be of an administrative or medical nature. Administrative appeals question plan benefit decisions such as whether a particular service is covered or paid appropriately. Medical appeals refer to the determination of medical need, appropriateness of treatment, or experimental and/or investigational procedures.

The following information must be given at the time of each inquiry.

- Name(s) and address(es) of patient and employee;
- employee's identification number;
- date(s) of service(s);
- provider's name and identification number;
- the specific remedy being sought; and
- the reason you think the claim should be reconsidered.

If you have any additional information or evidence about the claim that was not given when the claim was first submitted, be sure to include it.

Any member of the Dental Expense Plan who disagrees with a final decision of Aetna may request, in writing, that the matter be considered by the State Health Benefits Commission. Requests for consideration must be directed to the Appeals Coordinator, State Health Benefits Commission, PO Box 299, Trenton, NJ 08625-0299 and must contain the reason for the disagreement and a copy of all relevant correspondence. Appeals are considered at regular monthly meetings of the Commission. It is the responsibility of the member to provide the Commission with any medical or other information that the Commission may require in order to make a decision.

Any member of a DPO who disagrees with a determination of the appropriateness of a procedure made by a DPO or any member of a DPO who feels that the DPO has violated the terms and conditions of its contract with the SHBP may request, in writing, that the matter be considered by the State Health Benefits Commission. Such an appeal can only be considered after the member has exhausted the DPO's grievance process.

Upon request, your DPO will supply you with its grievance procedures. Requests for consideration must be directed to the Appeals Coordinator, State Health Benefits Commission, PO Box 299, Trenton, NJ 08625-0299 and must contain the reason for the disagreement and a copy of all relevant correspondence and supporting documentation. Appeals are considered at regular monthly meetings of the Commission.

Notification of all Commission decisions will be made in writing to the member. If the Commission denies the member's appeal, the member will be informed of further steps (s)he may take in the denial letter from the Commission. Any member who disagrees with the Commission's decision may request within 45 days in writing to the Commission that the case be forwarded to the Office of Administrative Law. The Commission will then determine if a factual hearing is necessary. If so, the case will be forwarded to the Office of Administrative Law. An Administrative Law judge will hear the case and make a recommendation to the Commission, which the Commission may adopt, modify, or reject. If a factural hearing is not necessary, the administrative appeal process involving the Commission is ended. When the administrative process is completed, further appeals may be made to the Superior Court of New Jersey, Appellate Division.

If your case is forwarded to the Office of Administrative Law, you will be responsible for the presentation of your case and for submitting all evidence. You will be responsible for any expenses involved in gathering evidence or material that will support your grounds for appeal. If you take your appeal to Superior Court, you will be responsible for any court filing fees or similar related costs that may be necessary during the appeal's process. If you require an attorney or expert medical testimony, you will be responsible for any fees or costs incurred.

AUDIT OF DEPENDENT COVERAGE

Periodically, the SHBP performs an audit using a random sample of members to determine if dependents are eligible under plan provisions. Proof of dependency such as a marriage certificate or birth certificate is required. Coverage for ineligible dependents will be terminated. Failure to respond to the audit will result in the termination from coverage of dependents.

SECTION TWO

THE DENTAL EXPENSE PLAN

The Dental Expense Plan is an indemnity plan that will reimburse you for a portion of the expenses you, and your enrolled dependents, incur for dental care provided by dentists or physicians licensed to perform dental services in the state in which they are practicing. Not all dental services are eligible for reimbursement, and some services are eligible only up to a limited amount. (For example, orthodontic services are reimbursed differently than other services.) Diagnostic/preventive and orthodontic services, are not subject to the deductible. For all other services, a deductible amount must be met before expenses are reimbursed. You are responsible for making the full payment of all charges to your dentist.

The Dental Expense Plan has been established by the State as a self-funded plan. The State currently contracts with Aetna to act as the administrative agent for the Plan.

As a Dental Expense Plan member you may be able to take advantage of a special Aetna network of participating dental providers. In this network called (PPO), participating dental providers contract with Aetna for a discounted fee schedule. When you use a participating dental provider, you only pay the provider any applicable deductible and the appropriate coinsurance based on the discounted fee, thereby reducing your out-of-pocket cost. In many cases the participating dental provider will submit the claims directly to Aetna, eliminating the necessity of your filing claim forms. To find out if your provider participates in the discounted network, call Aetna at 1-877-238-6200.

Deductibles

Diagnostic/preventive and orthodontic services are not subject to a deductible amount. For other services, the first $50 of covered expenses that you or your dependent(s) incur in a calendar year is not eligible for reimbursement. However, if there are four or more members of your family in the Plan, no additional deductibles are charged after any three members have each met their $50 deductible.

Reasonable and Customary Charges

The Dental Expense Plan covers only that part of a provider's charge for a service or supply that is reasonable and customary. Generally speaking, a charge by your dentist, or by any other provider of services or supplies, is considered reasonable and customary if it doesn't exceed the prevailing charge for the same service or supply made by similar providers in the same geographic area. It may differ from the actual amount that your dentist charges. You are responsible for the amount the dentist charges above the reasonable and customary allowances.

Levels of Reimbursement

After a person meets his or her $50 deductible (if applicable), the costs of all other eligible services for that person are reimbursed at a percentage of the reasonable and customary charge for the service (except where certain limits apply and subject to benefit maximums). The reimbursement percentages are as follows:

100% Diagnostic and Preventive (No deductible applicable)

80% Basic Services

65% Major Restorative

50% Periodontics and Prosthodontics

50% Orthodontics (No deductible applicable; separate $1000 lifetime benefit maximum)

A general description of each category of services is provided below. Refer to "Services That are Eligible for Reimbursement" (beginning on page 16) for any limitations that may apply to the services described below.

Diagnostic and Preventive services are precautionary services and are intended to maintain oral health and reduce the effects of tooth decay or gum disease which could lead to an increased need for more costly restorative services. They include the following:

- Oral Evaluations (includes comprehensive, periodic, limited, and specialist oral evaluations)
- Prophylaxis (cleaning of the teeth, including scaling and polishing procedures)
- Fluoride Treatments (topical application of fluoride for children under age 19)
- X-rays (limitations may apply)
- Laboratory and other Diagnostic Tests

Basic Services include:

- Emergency Treatment (Palliative only)
- Space Maintainers (i.e., passive appliances – can be fixed or removable)
- Simple Extractions
- Surgical Extractions
- Oral Surgery
- Anesthesia Services
- Basic Restorations (i.e., amalgam restorations and resin restorations)
- Endodontics (i.e., treatment of diseases of the dental pulp, including root canal and associated therapy)
- Repairs to removable dentures

Major Restorative services include those services that restore existing teeth. These services require a dentist to make an impression of the teeth and have an outside laboratory make a replacement. These services are utilized only if a tooth can not be restored with an amalgam, acrylic, synthetic porcelain, or composite filling restoration. Inlays/Onlays/Crowns are typical examples of major restorative services.

Periodontal services include those services involving the maintenance, reconstruction, regeneration and treatment of the supporting structures surrounding teeth, including bone, gum tissue, and root surfaces.

Prosthodontic services include both removable and fixed dentures (bridges) replacing missing teeth.

Orthodontic services look to correct abnormalities in tooth position (malposition) or abnormal bite (malocclusion), and use appliances such as retainers or braces.

Annual Benefit Maximum

The most the plan will pay for any one person in any one calendar year is $3,000. This maximum

applies to all eligible services except orthodontic, which has a separate $1,000 lifetime benefit maximum.

How Payments Are Made

Normally, reimbursements will be made to the Dental Expense Plan subscriber. The Plan subscriber may, however, authorize Aetna to send the reimbursement directly to the dental provider by completing the appropriate part of the claim form.

Additionally, whenever a law or court order requires the payment of dental expense benefits under the Plan to be made to a person or facility other than the Plan subscriber, the payment will be made to that person or facility upon proper notification (letter and a copy of the order/law).

Predetermination of Benefits

Predetermination allows you to know what services are covered and what payments will be made for treatment before the work is done. If you or one of your dependents are likely to incur dental expenses over $300, it is strongly recommended that you ask your dentist to file for predetermination of benefits.

You **must** obtain an approval in advance from Aetna whenever the service includes charges for crowns, inlays, onlays, periodontics, prosthodontics (removable or fixed), or orthodontics regardless of the cost. **Without advance approval these services will not be reimbursed.**

This feature of the Dental Expense Plan ensures that both you and the dentist will know in advance what part of the dentist's charges the Plan will pay. If possible, treatment should be completed within 90 days of receiving the approved predetermination.

Alternate Procedures

Usually there are several ways to treat a particular dental problem. Aetna will base its payment on the least costly treatment so long as the result meets acceptable dental standards.

The predetermination of benefits provision of the Dental Expense Plan is important because under the alternate procedures provision, Aetna has the right to pay the reasonable and customary amount for the method of treatment that does the job both properly and most economically. If you and the dentist decide you want a more costly treatment method, you are responsible for the charges beyond those for the less costly, appropriate treatment.

Exceptions for Predetermination

Predetermination is **not required** for services rendered for emergency treatment, routine oral examinations, X-rays, prophylaxes, and fluoride treatments.

Here's How It Works

Aetna determines the amount the Dental Expense Plan will pay and informs you and the dentist of its payment decision. You and your dentist should discuss the payment before the work is started.

Predetermination of benefits will help you avoid surprises. Most dentists are familiar with predetermination procedures, but if not, they should call Aetna at 1-877-238-6200.

If your dentist submits a treatment plan for predetermination of benefits and then alters the course of treatment, Aetna will adjust its payments accordingly. If the dentist makes a major change in the treatment plan, he/she should send in a revised plan.

DENTAL BENEFITS AT A GLANCE

Annual Deductible Amount of covered expenses you must pay each calendar year, before the plan begins to pay benefits	Diagnostic/Preventive Care: $0 Orthodontic: $0 Other Services: $50 per individual; $150 per family
Coinsurance Percent of covered expenses paid by the plan, after any applicable deductibles have been met, subject to reasonable and customary allowances	100% Diagnostic/Preventive 80% Basic Restorative 65% Major Restorative 50% Periodontics & Prosthodontics
Benefit Maximum	$3,000 Annual
Orthodontics	50% to $1,000 lifetime maximum (not subject to deductible and does not count towards the annual benefit maximum)

SERVICES THAT ARE ELIGIBLE FOR REIMBURSEMENT

(Please see the Glossary on page 31 for definition of terms.)

- Oral evaluations (limited to once per 6 month interval).
- X-rays. (horizontal bitewing X-rays limited to one series of up to 4 films per six month interval; vertical bitewing X-rays limited to one series of up to 8 films per 12 month interval; set of full mouth X-rays limited to once per 36 month interval; no more than 18 films per set of full mouth periapical X-rays).
- Oral prophylaxis, including scaling (not including scaling performed by a periodontist) and polishing (limited to once per 6 month interval).
- Topical application of fluoride for children under age 19 limited to once per 6 month interval.
- Sealants (limited to once per lifetime for permanent molars of eligible dependent children under the age of 19 years).
- Prosthodontic procedures (the replacement of an existing removable prosthetic appliance is covered only after a 5 year period measured from the date on which the appliance was previously placed).
- Periodontic procedures (reimbursement for periodontal surgical procedures, usually provided for a specific quadrant, is limited to one surgical-type procedure every 36 months). Reimbursement for periodontal root planing and scaling procedures per specific quadrant is limited to one procedure per 12 month interval).
- Periodontal surgical procedures, usually provided for specific quadrants, are subject to a reduced reimbursement when the number of diseased teeth in a quadrant are less than 4. Additional reduction in benefits may apply, when multiple types of procedures are provided in the same quadrant, at the same appointment.

- Restorative procedures, including fillings (other than gold), inlays, onlays, and crowns (the replacement of a crown is covered only after a 5 year period measured from the date on which the crown was previously placed).
- Emergency palliative treatment.
- Extractions of teeth.
- Endodontic services, such as pulpotomy and root canal therapy.
- Space maintainers.
- Oral surgery for surgical extractions, treatment of fractures, removal of lesions of the mouth, and alveolectomy.
- Apicoectomy.
- General anesthesia (including conscious sedation coverage) when medically necessary and in connection with covered oral and periodontal surgical procedures.

Charge Limits on Services

Two or more services may each be suitable for the dental care of a specific condition, under usual dental practice. If a charge is incurred for one of these services, Aetna may consider the charge to have been incurred for the other service which would have produced a professionally acceptable result, as determined by Aetna, and may pay only the lower of the two services.

Services That Are *Not* Eligible for Reimbursement

- Any orthodontic service prior to the employee attaining 10 months of employment or for any member over 19 years of age (see the separate section for special coverage for orthodontic service).
- Gold restorations other than crowns, inlays, and onlays.
- Any service or item not reasonably necessary for the dental care of the patient.
- Endosteal, subperiosteal and transosteal tooth implants, protective devices such as athletic mouth guards, plaque control, or myofunctional therapy.
- A charge in connection with appliances, restorations, or procedures needed to alter vertical dimensions or restore occlusion, or for the purpose of splinting or correcting attrition, abrasion, or erosion.
- Crowns, inlays, or onlays if used in splinting procedures during periodontal treatment.
- A service for cosmetic purposes.
- Any charge for a supply that is normally for home use such as toothpaste, tooth-brushes, water-pick, or mouthwash.
- A dental examination when required as a condition of employment by an employer, a government agency, or the terms of a labor agreement.
- A service or material which was furnished only because the charge would be paid under the Dental Expense Plan.
- A service or supply due to a war or any act of war.
- A service not furnished by a dentist or physician licensed to provide the dental service, except for a service performed by a licensed dental hygienist under the direction of a dentist.
- A service rendered by a provider that is beyond the scope of the provider's license.
- A charge made by a dentist for a failure of the patient to keep an appointment.

- A charge for the completion of any claim forms.
- A charge in connection with any procedure started before the patient was eligible for reimbursement in this program; except that a procedure will not have been considered to have started with an oral prophylaxis or a diagnostic procedure.
- Any service or supply other than those specifically covered under this program.
- Any service or supply which is furnished or made available to a patient or financed by federal, State, or local government, including Medicare or a like program, Workers' Compensation law or a similar law, any automobile no-fault law, or any other program or law under which the patient is or could be covered, whether or not the patient makes any claim or receives compensation under it.
- Any charge incurred after the patient is no longer covered, except in the case of an Extension of Coverage (see page 7).
- Any charge for a service that is more than the reasonable and customary dental charge (see page 13).
- Any charge for a service rendered by a member of the patient's immediate family (including you, your spouse, your child, brother, sister, or parent of you or your spouse).
- Charges where pre-approval is required but was not submitted for review (see page 15).
- Charges for sterilization or asepsis.

ORTHODONTIC SERVICES

Certain charges for orthodontic procedures are eligible if:

- You have been a full-time employee for at least 10 months.
- The orthodontic treatment is for a child covered under the Dental Expense Plan who is less than 19 years old.
- The procedure involves the use of active appliances to move teeth in order to correct the faulty position of teeth (malposition) or abnormal bite (malocclusion).
- The service or supply is part of a treatment plan submitted by the dentist and approved by Aetna with an estimate of the benefits that are payable.
- The service or supply is furnished before the end of the estimated duration of the treatment as recorded in the treatment plan.
- An active appliance for the procedure is inserted while the person is eligible for benefits in this program.

Orthodontic Benefits

Eligible orthodontic services will be covered at a 50 percent coinsurance level, up to a lifetime benefit maximum of $1,000. There is no deductible for orthodontic services.

Orthodontic Charges That Are *Not* Eligible

- Charges that are eligible for coverage under the regular dental care portion of the program.
- Charges for an orthodontic procedure started prior to the day on which the person became covered under the program or eligible for orthodontic benefits.

- Charges not reasonably necessary for orthodontic care.
- Any charges incurred for orthodontic procedures or treatment begun on or after the date the person attains age 19.

COORDINATION OF BENEFITS WITH OTHER INSURANCE PLANS

There is no coordination of benefits between the two State Group Dental Program plans because no individual is eligible for coverage in more than one State Group Dental Program plan.

If you and your dependents are also covered for dental expenses by other plans, certain rules apply that determine which plan provides the primary coverage and how much each plan will reimburse you. The purpose of these rules is to prevent a combined reimbursement from both plans that exceeds the expenses that you actually incur. Although there may be special cases not described here, the basic determination of which plan provides primary coverage is as follows:

- The employee's primary dental coverage is provided by the Dental Expense Plan.
- If your spouse is enrolled as your dependent and is also covered by a dental plan through his or her employer, your spouse's primary coverage is through the dental plan offered by his or her employer.
- If your children are enrolled as dependents in your plan and your spouse's plan, their primary coverage is provided by the dental plan of the parent whose birthday falls earlier in the year. If your spouse's plan does not follow this rule, then the rule in the other program will determine the order of benefits.
- In the case of a separation or divorce, the primary coverage for a child is provided in this order: by the plan of the parent who is legally responsible for the dental expenses of the child; by the plan of the parent with custody of the child; by the plan of the spouse of the parent with custody of the child; or by the plan of the noncustodial parent.

SECTION THREE

THE DENTAL PLAN ORGANIZATIONS

A Dental Plan Organization (DPO) is similar to a medical Health Maintenance Organization (HMO) program. The full cost for most services is prepaid to your dentist, but certain services require an additional copayment from you. Also, if you choose a more expensive treatment than deemed appropriate by your dental provider, you must pay the extra cost. Further, you will not be covered for services if you go to a dentist who is not a member of your DPO, unless referred by your DPO dentist.

There are many Dental Plan Organizations in the State Group Dental Program. Among these organizations, there are two types of plans – Dental Center and Individual Practice Associations (IPA).

- Dental Centers employ a group of dentists and technicians who are located at a central office. In a Dental Center Plan, you do not have the option to select a particular dentist unless permitted by the Dental Center.
- An Individual Practice Association (IPA) consists of a network of participating dentists who work in their own offices. If you choose an IPA, you must select a specific dentist in the IPA who will treat you and your dependents.

Some DPOs offer both a dental center and a list of participating dentists, thereby giving you the option of selecting a center or a particular dentist.

The DPO is responsible for providing all of the services that are listed as covered on pages 21 to 30 of this booklet. If the participating dentist that you have selected does not provide a specific service, then the DPO must refer you to another participating dentist located within 10 miles of your dentist's office (or 20 miles for orthodontic service). If you agree, the DPO may also refer you to a dentist located beyond these limits.

If the DPO has no participating dentist who can provide the service in your geographical area, then the DPO must refer you to a nonparticipating dentist within the 10 or 20 mile limit. If there is no dentist within this area, then you must be referred to the dentist closest to your dentist's office.

- If the DPO dentist refers you to another dentist and that referral is approved by the DPO, then you will have the same coverage for the service as if you had been treated by your dentist. However, if you select an outside dentist on your own, the service you receive will not be covered.

CONSIDERATIONS IN CHOOSING A DPO

- Obtain a list of DPOs and participating dentists from your benefits administrator. If you choose a dentist rather than a Dental Center, check with the DPO and the dentist to be sure that the dentist is a member of the DPO, services State Group Dental Program members, and will accept you as a new patient.
- If you choose a dentist, you should also check with the dentist to make sure that he or she plans to stay in the DPO. If the dentist leaves, you will then have to select another dentist in that DPO.
- You should also check to determine that the DPO dentist or center could serve the needs of your entire family and whether the days and hours of operation are convenient for you and your family.
- If your dentist leaves the DPO, and there are no other dentists in the DPO within 30 miles of your home, you may switch to another dental plan (either another DPO or the Dental Expense Plan).

COORDINATION OF BENEFITS WITH OTHER INSURANCE PLANS

There is no coordination of benefits between the two State Group Dental Program plans because no individual is eligible for coverage in more than one State Group Dental Program plan.

If you and your dependents are also covered for dental expenses by other plans, certain rules apply that determine which plan provides the primary coverage and how much each plan will reimburse you. The purpose of these rules is to prevent a combined reimbursement from both plans that exceeds the expenses that you actually incur. Although there may be special cases not described here, the basic determination of which plan provides primary coverage is as follows:

- The employee's primary dental coverage is provided by the DPO.
- If your spouse is enrolled as your dependent and is also covered by a dental plan through his or her employer, your spouse's primary coverage is through the dental plan offered by his or her employer.
- If your children are enrolled as dependents in your plan and your spouse's plan, their primary coverage is provided by the dental plan of the parent whose birthday falls earlier in the year. If your spouse's plan does not follow this rule, then the rule in the other program will determine the order of benefits.
- In the case of a separation or divorce, the primary coverage for a child is provided in this order: by the plan of the parent who is legally responsible for the dental expenses of the child; by the plan of the parent with custody of the child; by the plan of the spouse of the parent with custody of the child; or by the plan of the noncustodial parent.

COVERED SERVICES

The following is a list of covered services and, if applicable, copayments. Copayment means what you must pay for the service. Some of these terms may be unfamiliar to you. Please see the Glossary on page 31.

Codes	Description of Covered Services	Copayments
D0100-D0999	**I. DIAGNOSTIC**	
Clinical Oral Examination		
(Oral evaluations are limited to once per 6 month interval)		
D0120	Periodic Oral Evaluation	$ 0
D0140	Limited Oral Evaluation	0
D0150	Comprehensive Oral Evaluation	0
D0160	Detailed and Extensive Oral Evaluation	0
Radiographs		
(Bitewing X-rays are limited to one series of up to 4 films per 6 month interval; set of full mouth X-rays are limited to once per 36 month interval; no more than 18 films per set of mouth X-rays)		
D0210	Intraoral-Complete Series Including Bitewings	$ 0
D0220	Intraoral-Periapical-First Film	0
D0230	Intraoral-Periapical-Each Additional Film	0
D0240	Intraoral-Occlusal Film	0
D0250	Extraoral-First Film	0

D0260	Extraoral-Each Additional Film	$ 0
D0270	Bitewings-Single Film	0
D0272	Bitewings-Two Films	0
D0274	Bitewings-Four Films	0
D0277	Vertical Bitewings-Eight Films	0
D0290	Posterior-Anterior or Lateral Skull and Facial Bone Survey Film	0
D0330	Panoramic Film	0
D0340	Cephalometric Film	0

Tests and Laboratory Examinations

D0415	Bacterial Studies for Determination of Pathologic Agents	$ 0
D0425	Caries Susceptibility Tests	0
D0460	Pulp Vitality Tests	0
D0470	Diagnostic Casts	0

D1000-D1999 II. PREVENTIVE

Dental Prophylaxis
(Limited to once per 6 month interval)

D1110	Prophylaxis-Adult	$ 0
D1120	Prophylaxis-Child	0

Topical Fluoride Treatment *(Office Procedure)*
(Limited to once per 6 month interval, and only for eligible dependent children under the age of 19 years)

D1201	Application Including Prophylaxis-Child	$ 0
D1203	Application Excluding Prophylaxis-Child	0
D1204	Application Excluding Prophylaxis-Adult	0
D1205	Application Including Prophylaxis-Adult	0

Other Preventive Services
(Sealants are limited to once per lifetime for permanent molars of eligible dependent children under the age of 19 years)

D1330	Oral Hygiene Instruction	$ 0
D1351	Sealant-Per Tooth	0

Space Maintenance *(Passive Appliances)*

D1510	Space Maintainer-Fixed Unilateral	$ 0
D1515	Space Maintainer-Fixed Bilateral	0
D1520	Space Maintainer-Removable-Unilateral	0
D1525	Space Maintainer-Removable—Bilateral	0
D1550	Recementation of Space Maintainer	0

D2000-D2999 III. RESTORATIVE

(The replacement of a crown is covered only after a 5 year period measured from the date on which the crown was previously placed)

Amalgam Restorations *(Including Polishing)*

D2110	Amalgam-One Surface Primary	$ 0
D2120	Amalgam-Two Surfaces Primary	0
D2130	Amalgam-Three Surfaces Primary	0
D2131	Amalgam-Four or More Surfaces Primary	0

D2140	Amalgam-One Surface Permanent	$ 0
D2150	Amalgam-Two Surfaces Permanent	0
D2160	Amalgam-Three Surfaces Permanent	0
D2161	Amalgam-Four or More Surfaces Permanent	0

Resin Restorations

D2330	Resin-One Surface Anterior	$ 0
D2331	Resin-Two Surfaces Anterior	0
D2332	Resin-Three Surfaces Anterior	0
D2335	Resin-Four or more Surfaces Anterior, or Involving Incisal Angle	0
D2336	Composite Resin Crown-Anterior-Primary	35
D2337	Composite Resin Crown Anterior-Permanent	35
D2380	Resin-One Surface Posterior-Primary	15
D2381	Resin-Two Surfaces Posterior-Primary	25
D2382	Resin-Three or more Surfaces Posterior-Primary	35
D2385	Resin-One Surface Posterior-Permanent	15
D2386	Resin-Two Surfaces Posterior-Permanent	25
D2387	Resin-Three Surfaces Posterior-Permanent	35
D2388	Resin Four or more Surfaces Posterior-Permanent	45

Inlay/Onlay Restorations

D2510	Inlay-Metallic-One Surface	$ 100
D2520	Inlay-Metallic-Two Surfaces	100
D2530	Inlay-Metallic-Three or more Surfaces	100
D2542	Onlay-Metallic-Two Surfaces	100
D2543	Onlay-Metallic-Three Surfaces	100
D2544	Onlay-Metallic-Four or More Surfaces	100
D2610	Inlay-Porcelain/Ceramic-One Surface	115
D2620	Inlay-Porcelain/Ceramic-Two Surfaces	115
D2630	Inlay-Porcelain/Ceramic-Three or More Surfaces	115
D2642	Onlay-Porcelain/Ceramic-Two Surfaces	115
D2643	Onlay-Porcelain/Ceramic-Three Surfaces	115
D2644	Onlay-Porcelain/Ceramic-Four or More Surfaces	115
D2650	Inlay-Composite/Resin-One Surface *(Lab Process)*	115
D2651	Inlay-Composite/Resin-Two Surface *(Lab Process)*	115
D2652	Inlay-Composite/Resin-Three or More Surfaces (Lab *Process)*	115
D2662	Onlay-Composite/Resin-Two Surfaces *(Lab Process)*	115
D2663	Onlay-Composite/Resin-Three Surfaces *(Lab Process)*	115
D2664	Onlay-Composite/Resin-Four or more Surfaces *(Lab Process)*	115

Crowns - Single Restorations Only

D2710	Crown-Resin-Laboratory (see note on page 24)	$ 115
D2720	Crown-Resin with High Noble Metal	150
D2721	Crown-Resin with Predominantly Base Metal	150
D2722	Crown-Resin with Noble Metal	150
D2740	Crown-Porcelain/Ceramic Substrate	200
D2750	Crown-Porcelain Fused to High Noble Metal	225
D2751	Crown-Porcelain Fused to Predominantly Base Metal	200
D2752	Crown-Porcelain Fused to Noble Metal	200
D2780	Crown ¾ Cast High Noble Metal	225
D2781	Crown ¾ Cast Predominantly Base Metal	200
D2790	Crown-Full Cast High Noble Metal	225

D2791	Crown-Full Cast Predominantly Base Metal	$200
D2792	Crown-Full Cast Noble Metal	200

Other Restorative Services

D2910	Re-cement Inlay	$ 0
D2920	Re-cement Crown	0
D2930	Prefabricated Stainless Steel Crown-Primary Tooth	35
D2931	Prefabricated Stainless Steel Crown-Permanent Tooth	35
D2932	Prefabricated Resin Crown	35
D2933	Prefab Stainless Steel Crown with Resin Window	35
D2940	Sedative Fillings	0
D2950	Buildup Including Any Pins	0
D2951	Pin Retention-Per Tooth in Addition to Restoration	0
D2952	Cast Post & Core in Addition to Crown	40
D2954	Prefabricated Post & Core in Addition to Crown	40
D2955	Post Removal *(Not in Conjunction with Endodontic Therapy)*	0
D2970	Temporary Crown *(Fractured Tooth)*	0
D2980	Crown Repair - By Report	0

Note: There is no copayment for procedure D2710 when performed in conjunction with a permanent crown on the same tooth.

D3000-D3999 IV. ENDODONTICS

Pulp Capping

D3110	Pulp Capping-Direct Excluding Final Restoration	$ 0
D3120	Pulp Capping-Indirect Excluding Final Restoration	0

Pulpotomy

D3220	Therapeutic Pulpotomy Excluding Final Restoration	$ 25

Endodontic Therapy on Primary Teeth

D3230	Pulpal Therapy (Resorbable Filling)-Anterior-Primary Tooth	$ 20
D3240	Pulpal Therapy (Resorbable Filling)-Posterior-Primary Tooth	20

Endodontic Therapy

D3310	Anterior (Excluding Final Restoration)	$100
D3320	Bicuspid (Excluding Final Restoration)	125
D3330	Molar (Excluding Final Restoration)	150

Endodontic Retreatment

D3346	Retreat Previous Root Canal-Anterior	$125
D3347	Retreat Previous Root Canal-Bicuspid	150
D3348	Retreat Previous Root Canal-Molar	175

Apexification/Recalcification Procedures

D3351	Apexification/Recalcification-Initial Visit	$ 35
D3352	Apexification/Recalcification-Interim Medication Replacement	35
D3353	Apexification/Recalcification-Final Visit	35

Apicoectomy/Periapical Services

D3410	Apicoectomy/Periradicular Surgical-Anterior	$ 90
D3421	Apicoectomy/Periradicular Surgical-Bicus First Root	90
D3425	Apicoectomy/Periradicular Surgical-Molar First Root	90
D3426	Apicoectomy/Periradicular Surgical-Each Add Root	40
D3430	Retrograde Filling-Per Root	20
D3450	Root Amputation-Per Root	40

Other Endodontic Procedures

D3910	Surgical Procedure for Isolation of Tooth with Rubber Dam	$ 0
D3920	Hemisection (Including Any Root Removal), Not Including Root Canal Therapy	60

D4000-D4999 V. PERIODONTICS

(Coverage for surgical periodontal procedures, excluding scaling and root planing, is limited to one surgical periodontal treatment per quadrant every 36 months; coverage for scaling and root planing is limited to one nonsurgical periodontal treatment per quadrant every 12 months)

Surgical Services

D4210	Gingivectomy/Gingivoplasty-Per Quadrant	$ 85
D4211	Gingivectomy/Gingivoplasty-Per Tooth	30
D4240	Gingival Flap Procedure Including Root Planing-Per Quadrant	90
D4245	Apically Positioned Flap	90
D4249	Crown Lengthening-Hard Tissue	90
D4260	Osseous Surgery (Including Flap Entry & Closure)-Per Quadrant	175
D4263	Bone Replacement Graft-First Site in Quadrant	100
D4264	Bone Replacement Graft-Each Addition Site in Quadrant	50
D4266	Guided Tissue Regeneration-Resorbable Barrier	90
D4267	Guided Tissue Regeneration-Non-resorbable Barrier	90
D4270	Pedicle Soft Tissue Graft Procedure	175
D4271	Free Soft Tissue Graft Procedure (Including Donor Site)	175
D4273	Subepithelial Connective Tissue Graft Procedure	175
D4274	Distal or Proximal Wedge Procedure	40

Adjunctive Periodontal Services

D4320	Provisional Splinting-Intracoronal	$ 0
D4321	Provisional Splinting-Extracoronal	0
D4341	Periodontal Root Planing-Per Quadrant	55
D4355	Full Debridement, Enable Complete Periodontal Evaluation	55

Other Periodontal Services

D4910	Periodontal Maintenance Procedures After Active Therapy	$ 30
D4920	Unscheduled Dressing Change (By Someone Other than Treating Dentist)	0

D5000-D5999 VI. PROSTHODONTICS (REMOVABLE)

(The replacement of an existing removable prosthetic appliance is covered only after a 5 year period measured from the date on which the appliance was previously placed)

Complete Dentures (Including Routine Post Delivery Care)

D5110	Complete Denture-Maxillary	$250
D5120	Complete Denture-Mandibular	250
D5130	Immediate Denture-Maxillary	275
D5140	Immediate Denture-Mandibular	275

Partial Dentures (Including Routine Post Delivery Care)

D5211	Maxillary Partial Denture-Resin Base (Including any Conventional Clasps, Rests and Teeth)	$250
D5212	Mandibular Partial Denture-Resin Base (Including any Conventional Clasps, Rests and Teeth)	250
D5213	Maximum Partial Denture-Cast Metal Framework w/Resin Denture Bases (Including any Conventional Clasps, Rests & Teeth)	275
D5214	Mandibular Partial Denture-Cast Metal Framework w/Resin Denture Bases (Including any Conventional Clasps, Rests & Teeth)	275
D5281	Removable Unilateral Partial Denture-One Piece Cast Metal (Including Clasps & Teeth)	125

Adjustments to Removable Prostheses

D5410	Adjust Complete Denture-Maxillary	$ 0
D5411	Adjust Complete Denture-Mandibular	0
D5421	Adjust Partial Denture-Maxillary	0
D5422	Adjust Partial Denture-Mandibular	0

Repairs to Complete Dentures

D5510	Repair Broken Complete Denture Base	$ 35
D5520	Replace Missing or Broken Teeth-Complete Denture-Each Tooth	35

Repairs to Partial Dentures

D5610	Repair Resin Denture Base	$ 35
D5620	Repair Cast Framework	35
D5630	Repair or Replace Broken Clasp	35
D5640	Replace Broken Teeth-Per Tooth	35
D5650	Add Tooth to Existing Partial Denture	35
D5660	Add Clasp to Existing Partial Denture	35

Denture Rebase Procedures

D5710	Rebase Complete Maxillary Denture	$ 85
D5711	Rebase Complete Mandibular Denture	85
D5720	Rebase Maxillary Partial Denture	85
D5721	Rebase Mandibular Partial Denture	85

Denture Reline Procedures

D5730	Reline Complete Maxillary Denture-Chairside	$ 40
D5731	Reline Complete Mandibular Denture-Chairside	40
D5740	Reline Maxillary Partial Denture-Chairside	40
D5741	Reline Mandibular Partial Denture-Chairside	40
D5750	Reline Complete Maxillary Denture-(Lab Process)	40
D5751	Reline Complete Mandibular Denture-(Lab Process)	40
D5760	Reline Maxillary Partial Denture-(Lab Process)	40
D5761	Reline Mandibular Partial Denture-(Lab Process)	40

Other Removable Prosthetic Services

D5810	Interim Complete Denture (Maxillary)	$ 95
D5811	Interim Complete Denture (Mandibular)	95
D5820	Interim Partial Denture (Maxillary)	65
D5821	Interim Partial Denture (Mandibular)	65
D5850	Tissue Conditioning (Maxillary)	15
D5851	Tissue Conditioning (Mandibular)	15

D6200-D6999 IX. PROSTHODONTICS, FIXED

Fixed Partial Denture Pontics

D6210	Pontic-Cast High Noble Metal	$225
D6211	Pontic-Cast Predominantly Base Metal	200
D6212	Pontic-Cast Noble Metal	200
D6240	Pontic-Porcelain Fused to High Noble Metal	225
D6241	Pontic-Porcelain Fused to Predominantly Base Metal	200
D6242	Pontic-Porcelain Fused to Noble Metal	200
D6245	Pontic Porcelain/Ceramic	200
D6250	Pontic-Resin with High Noble Metal	150
D6251	Pontic-Resin with Predominantly Base Metal	150
D6252	Pontic-Resin with Noble Metal	150

Fixed Partial Denture Retainers-Inlays/Onlays

D6520	Inlay-Metallic-Two Surfaces	$100
D6530	Inlay-Metallic-Three or More Surfaces	100
D6543	Onlay-Metallic-Three Surfaces	100
D6544	Onlay-Metallic-Four or More Surfaces	100
D6545	Retainer-Cast Metal for Resin Bonded Fixed Prosthesis	100

Fixed Partial Denture Retainers-Crown

D6720	Crown-Resin with High Noble Metal	$150
D6721	Crown-Resin with Predominantly Base Metal	150
D6722	Crown-Resin with Noble Metal	150
D6740	Crown Porcelain/Ceramic	200
D6750	Crown-Porcelain Fused to High Noble Metal	225
D6751	Crown-Porcelain Fused to Predominately Base Metal	200
D6752	Crown-Porcelain Fused to Noble Metal	200
D6780	Crown-3/4 Cast High Noble Metal	225
D6781	Crown 3/4 Cast Predominately Base Metal	200

D6782	Crown 3/4 Cast Noble Metal	$200
D6783	Crown 3/4 Porcelain/Ceramic	200
D6790	Crown-Full Cast High Noble Metal	225
D6791	Crown-Full Cast Predominantly Base Metal	200
D6792	Crown-Full Cast Noble Metal	200

Other Fixed Partial Denture Services

D6930	Recement Fixed Partial Denture	$ 15
D6970	Cast Post & Core in Addition to Bridge Retainer	40
D6971	Cast Post as Part of Fixed Partial Denture	40
D6972	Prefabricated Post & Core in Addition to Bridge Retainer	40
D6973	Core Buildup for Retainer Including Pins	0
D6980	Fixed Partial Denture Repair-By Report	25

D7000-D7999 X. ORAL AND MAXILLOFACIAL SURGERY

Extractions (Includes Local Anesthesia, Suturing, If Needed, and Routine Post-Operative Care

D7110	Single Tooth	$ 20
D7120	Each Additional Tooth	15
D7130	Root Removal-Exposed Roots	20

Surgical Extractions (Includes Local Anesthesia, Suturing, If Needed, and Routine Post-Operative Care

D7210	Surgical Removal of Erupted Tooth Requiring Elevation of Mucoperiosteal Flap & Removal of Bone and/or Section of Tooth	$ 30
D7220	Removal of Impacted Tooth-Soft Tissue	55
D7230	Removal of Impacted Tooth-Partially Bony	55
D7240	Removal of Impacted Tooth-Completely Bony	65
D7241	Removal of Impacted Tooth-Completely Bony with Complications	65
D7250	Surgical Removal of Residual Tooth Roots-Cutting Procedure	30

Other Surgical Procedures

D7260	Oroantral Fistula Closure	$100
D7270	Tooth Reimplantation/Stabilization	60
D7280	Surgical Exposure of Impacted/Unerupted Tooth-for Orthodontic Reasons	60
D7281	Surgical Exposure of Impacted/Unerupted Tooth-to Aid Eruption	60
D7285	Biopsy of Oral Tissue-Hard	60
D7286	Biopsy of Oral Tissue-Soft	25
D7291	Transseptal Fiberotomy-By Report	20

Alveoloplasty-Surgical Preparation of the Ridge for Dentures

D7310	Alveoloplasty in Conjunction with Extraction-Per Quad	$ 30
D7320	Alveoloplasty Not in Conjunction with Extractions-Per Quadrant	35

Removal of Cysts, Tumors and Neoplasms

D7430	Excision of Benign Tumor-Lesion Up to 1.25cm Diameter	$ 60
D7431	Excision of Benign Tumor-Lesion Greater than 1.25cm Diameter	60
D7450	Excision of Odontogenic Cyst or Tumor-Lesion Up to 1.25cm Diameter	60
D7451	Excision of Odontogenic Cyst or Tumor-Lesion Greater than 1.25cm Diameter	60
D7460	Excision of Non-Odontogenic Cyst or Tumor-Lesion Up to 1.25cm Diameter	60
D7461	Excision of Non-Odontogenic Cyst or Tumor-Lesion Greater than 1.25cm Diameter	60

Excision of Bone Tissue

D7471	Removal of Exostosis-Maxilla or Mandible	$ 90

Surgical Incision

D7510	Incision & Drainage of Abscess-Intraoral Soft Tissue	$ 25
D7520	Incision & Drainage of Abscess-Extraoral Soft Tissue	35

Other Repair Procedures

D7960	Frenulectomy-Separate Procedure	$ 60
D7970	Excision of Hyperplastic Tissue-Per Arch	60
D7971	Excision of Pericoronal Gingiva	30

Miscellaneous Services

D9110	Palliative (Emergency) Treatment of Dental Pain-Minor Procedure	$ 0
D9211	Regional Block Anesthesia	0
D9212	Trigeminal Division Block Anesthesia	0
D9215	Local Anesthesia	0
D9220	General Anesthesia-First 30 Minutes	40
D9221	General Anesthesia-Each Additional 15 Minutes	20
D9230	Analgesia	0
D9241	Intravenous Sedation, First 30 Minutes	40
D9242	Intravenous Sedation, Each Additional 15 Minutes	20
D9310	Consultation	0
D9430	Office Visit Observation	0
D9440	Office Visit After Hours	0
D9610	Therapeutic Drug Injection By Report	0
D9630	Other Drugs and/or Medications By Report	0
D9910	Application of Desensitizing Medication	0
D9930	Treat Complications By Report	0
D9940	Occlusal Guard-By Report	40
D9951	Occlusal Adjustment-Limited	0
D9952	Occlusal Adjustment-Complete	60

Orthodontics

(Treatment plan maximum of 24 months)

1. Patient under 18 years of age at the start of treatment — Class I, II, and III malocclusion (copayment required of $1,000 or 50% of bill, whichever is less).
2. Patient 18 years of age or over at the start of treatment — Class I, II, and III malocclusion (copayment required of $1,750 or 50% of bill, whichever is less).

Services That Are *Not* Covered By the DPO

- A service started before the person became a covered individual under the plan.
- A service covered under any medical or surgical or major medical plan (including a health maintenance organization) provided by the employer.
- Replacement of lost, stolen, or damaged prosthodontic devices within two years of the date of initial installation.
- A service not reasonably necessary for the dental care of a covered individual or provided solely for cosmetic purposes.
- Providing supplies of a type normally intended for home use, such as toothpaste, toothbrushes, waterpicks, and mouthwash.
- A service required because of war or an act of war.
- A service made available to a covered individual or financed by the federal government or a state or local government. This includes the federal Medicare program and any similar federal program, any Workers' Compensation law or similar law, any automobile no-fault law, or any other program or law under which the covered individual is, or could be, covered. The exclusion is applicable whether or not the covered individual receives the service, makes a claim or receives compensation for the service, or receives a recovery from a third party for damages.
- A service not furnished by a dentist. This is not applicable to a service performed by a licensed dental hygienist under the supervision of a dentist.
- General anesthesia, except when medically necessary in connection with covered oral and periodontal surgery procedures.
- Hospitalization.
- Any dental implant including any devices or appliances attached to implants.
- Experimental procedures.
- Appliances, restorations, and procedures to alter vertical dimension and/or restore occlusion, including temporomandibular joint dysfunction, except oral splints.
- Procedures not listed on pages 21-30.

More Expensive Services

A covered individual may elect a more expensive procedure than an appropriate procedure recommended by the DPO. The covered individual shall pay any copayment required for the less expensive procedure plus the difference in cost between the two procedures on the basis of the reasonable and customary dental charges for the procedures.

SECTION FOUR

APPENDIX A

GLOSSARY

Alveolectomy	Surgical excision of a portion of the dentoalveolar process, for re-contouring the tooth socket ridge at the time of tooth removal in preparation for a dental prosthesis (denture).
Apicoectomy	Surgical removal of a dental root apex. Root resection.
Bitewing X-Ray	X-rays taken with the film holder held between the teeth and the film parallel to the teeth.
Crossbite	An abnormal relation of one or more teeth of one arch to the opposing tooth or teeth of the other arch.
Crown	That part of a tooth that is covered with enamel or an artificial substitute for that part.
Endodontics	Concerned with the biology and pathology of the dental pulp and surrounding tissues. Root canal treatment.
Gingivectomy	Removal of gum tissue.
Gingivoplasty	A surgical procedure that reshapes and recontours the gum tissue in order to attain functional form.
Inlay	A cast metallic or ceramic filling for a dental cavity.
Mandibular	Relating to the lower jaw.
Maxillary	Relating to the upper jaw.
Myofunctional	Relating to the role of muscle function in the correction of oral problems.
Onlay	A type of metal restoration that overlays the tooth to provide additional strength to that tooth.
Orthodontic	Concerned with the correction and prevention of irregularities of the teeth. Dental orthopedics.
Osteoplasty	Resection of the bony structure to achieve acceptable gum contour.
Palliative Treatment	Alleviation of symptoms without curing the underlying disease.
Periodontics	Concerned with the treatment of abnormal conditions and diseases of the tissues that surround and support the teeth.
Pontic	An artificial tooth on a fixed partial denture.

Prophylaxis	A series of procedures whereby calculus (calcified deposits), stain, and other accretions are removed from the clinical crowns of the teeth and the enameled surfaces are polished.
Prosthodontics	The science of and art of providing suitable substitutes for crowns of teeth, or for replacing lost or missing teeth.
Pulpotomy	Removal of a portion of the pulp structure of a tooth, usually the coronal portion.
Scaling & Root	The removal of subgingival calcified deposits around the teeth and the cleaning of the gingival pocket.
Temporo-mandibular	Denoting the joint of the lower jaw.

APPENDIX B

NEW JERSEY STATE DENTAL PLANS

UNIT/ DPO #	NAME	MEMBERSHIP SERVICE PHONE #	SERVING*
301	Atlantic Southern Dental Foundation (BeneCare)	1-800-843-4727	All of New Jersey, Eastern Pennsylvania
302	Community Dental Associates	(856) 451-8844	Cumberland County
305	CIGNA Dental Health, Inc.	1-800-367-1037	All of New Jersey, Eastern Pennsylvania, Parts of New York
306	Group Dental Health Administrators, Inc.	(908) 241-9700	Mercer, Union, Middlesex & Essex Counties
307	Healthplex (International Health Care Services)	1-800-468-0600	All of New Jersey, Bucks County & Philadelphia
308	Protective Dental Care (Oracare)	1-800-672-2273	All of New Jersey, Eastern Pennsylvania
311	Unity Dental Health Services, P.A.	1-800-648-0146	All of New Jersey
312	Flagship Health Systems Inc.	1-800-722-3524	All of New Jersey
317	Horizon Dental Choice	1-800-433-6825	All of New Jersey
319	Aetna DMO	1-800-843-3661	All of New Jersey, Eastern Pennsylvania
399	Dental Expense Plan - Administered by Aetna USHC	1-877-238-6200	Unrestricted

*For specific areas of service, contact the DPO or see your benefits administrator for a list of dental providers for each DPO.

APPENDIX C

TAX$AVE

If you are a State employee, the premiums that you pay for dental plan coverage are exempt from federal taxes unless you have specifically declined participation in the Premium Option Plan of the State's Tax$ave Program. These premiums are deducted from your paycheck before federal income, Social Security, and Medicare taxes are taken out, thereby saving you money on taxes.

If you have elected to establish an Unreimbursed Medical Spending Account under the Tax$ave Program, then any eligible out-of-pocket expense (copayments, deductibles, coinsurances) that you make in the State Group Dental Program can be paid from that account. This also saves you tax dollars.

Fact Sheet #44, *Tax$ave,* outlines the Tax$ave Program and may be obtained from your benefits administrator or from the Division of Pensions and Benefits by calling the Benefit Information Library at (609) 777-1931. After the introduction, enter information selection number 266 when prompted. You will hear a recorded message about the Tax$ave program, after which you can request the fact sheet to be sent by mail or fax.

You can also visit the Division of Pensions and Benefits' Tax$ave Internet page at: *www.state.nj.us/Treasury/Pensions/Tax$ave.htm*

APPENDIX D

DIVISION OF PENSIONS AND BENEFITS

CONTACT INFORMATION

MAILING ADDRESSES:

Division of Pensions and Benefits
Office of Client Services
PO Box 295
Trenton, NJ 08625-0295

State Health Benefits Commission
Division of Pensions and Benefits
PO Box 299
Trenton, NJ 08625-0299

On all correspondence, be sure to include your Social Security number and a daytime telephone number.

TELEPHONE NUMBERS:

Division of Pensions and Benefits,

Office of Client Services — (609) 292-7524

Telephone Counselors available 9:00 a.m. to 4:00 p.m., Monday through Friday (except holidays).

TDD Phone (Hearing Impaired) — (609) 292-7718

Benefit Information Library — (609) 777-1931

Available 24 hours a day. *For recorded information on the State Group Dental Program enter information selection number 256 when prompted.*

COUNSELING SERVICES:

Division of Pensions and Benefits
Office of Client Services
50 West State Street, First Floor
Trenton, NJ

No appointment is necessary. Counselors are available 8:40 a.m. to 4:00 p.m., Monday through Friday (except holidays).

E-MAIL ADDRESS:

E-mail the Division of Pensions and Benefits at:
pensions_nj@tre.state.nj.us

INTERNET:

Division of Pensions and Benefits Internet Homepage:
www.state.nj.us/treasury/pensions

WE'VE GOT YOU COVERED